

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☒ Partnership – Pages 1,2,3,6
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: HDG Medical LLC, A Nevada limited Liability Company

Physical Address: 3900 S Hualapai Way, Suite 105, Las Vegas, NV 89147
(This must be a business address, we can not issue a license to a home address)

Mailing Address: PO BOX 371893

City: Las Vegas State: NV Zip Code: 89137

Telephone: 702-952-1705 Fax: 702-952-1706

E-mail: na@3ecp.com Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8am to 5pm Tue: 8am to 5pm Wed: 8am to 5pm Thu: 8am to 5pm
Fri: 8am to 5pm Sat: N/A to N/A Sun: N/A to N/A Holidays: N/A to N/A

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Christine Thornton

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

☐ Medical Gases** ☒ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☒ Orthotics and Prosthesis
☒ Diabetic Supplies Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

N/A		

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☒ No ☐
- 2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☒
- 3) Are any of the owners health professionals? If yes, please check the box and list name.
- | | |
|---|-------------|
| <input type="checkbox"/> Practitioner | Name: _____ |
| <input type="checkbox"/> Advanced Practitioner of Nursing | Name: _____ |
| <input type="checkbox"/> Physician's Assistant | Name: _____ |
| <input type="checkbox"/> Physical Therapist | Name: _____ |
| <input type="checkbox"/> Occupational Therapist | Name: _____ |
| <input type="checkbox"/> Registered Nurse | Name: _____ |
| <input type="checkbox"/> Respiratory Therapist | Name: _____ |

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

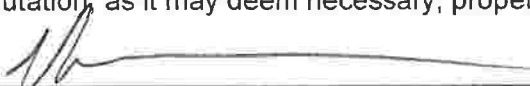
Within the last five (5) years:

- 1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

If the answer to questions 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG provider or wholesaler may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.



Original Signature of Person Authorized to Submit Application, no copies or stamps

Jeff Brouwer

Print Name of Authorized Person

Date

7/15/16

Board Use Only

Received:

8/9/16

Amount:

\$500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP

List names of 4 largest partners and percentage of ownership:

Name: Jeff Brouwer, Manager of CA Medical Solutions LLC %: 50

Name: Devin Thornton, Manager of Ohana Medical Consultants LLC %: 50

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: HDG Medical LLC, A Nevada limited Liability Company

Mailing Address: PO BOX 371893

City: Las Vegas State: NV Zip Code: 89137

Telephone Number: 702-952-1705 Fax Number: 702-952-1706

Contact Person: Nizar Alikhan

PARTNERSHIP

Include with the application for a partnership

Complete personal history record for each partner. Must be original signature(s), no copies or stamps. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 7/17/16

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made herein is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Medical Device Equipment and Gases

Nature of License
HDG Medical LLC, A Nevada limited Liability
 Name and Address of Establishment for Which License Is Requested
3900 S. Hualapai Way, Suite 105, Las Vegas, NV 89147

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name Thornton First Name Devin Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Present Residence Address-Street or RFD 3931 115th Ave SE City Snohomish State/Zip WA 98290

Present Business Address 3900 S. Hualapai Way Ste 105 City Las Vegas State/Zip NV 89147

Occupation Phone: Residence Business

Date of Birth 37 Place of Birth (City, County, State) Kansas City, Missouri

Age 37 Sex Male

Color of Eyes Brown Color of Hair Red Complexion Fair Weight 220 Build Athletic Height 5'11"

Scars, tattoos or distinguishing marks and/or characteristics Angel on back, Skull and cross on left shoulder, clover on right ankle

Are you a citizen of the United States? Yes ☒ No ☐ If alien, registration No

If naturalized, certificate No Date

Place (If naturalized, document must be verified)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial DT

MARITAL INFORMATION-Continued

A. Current Marriage

Spouse's full name (Maiden) Shawna Wergin Date _____ City, County and State _____
 S.S. No. _____
 Date of Birth _____ Place of Birth Las Vegas, NV
 Resident address 3931 115th Ave SE Spokane WA 98290
 Street City State Zip
 Telephone: Residence 21 Business _____
 Spouse's employer N/A Occupation N/A
 Address of employer N/A
 Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
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List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
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3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
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B. Child Support Information:

Please mark the appropriate response:

- ☒ I am not subject to a court order for the support of child.
- ☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- ☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial DT

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name

Address

Contact person

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-

in-law or legal guardian. If retired or deceased, list last address and occupation.

Name (Maiden)	Birth Date	Address	Occupation
Father Archie Thornton		4356 Horizon Dr Carlsbad CA 92008	Business
Mother Patricia Furtado	1954	1524 S. 328th St. Federal Way WA 98003	N/A
Father-in-Law John Wergin		7123 Foster Slough Rd Snohomish WA 98290	Delivery Driver
Mother-in-Law Julie Platko		3931 115th Ave SE Snohomish WA 98290	N/A

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
Mason Thornton		8584 Garnet Lake Ave Las Vegas NV 89113	Finance
Spouse Christine Thornton		8584 Garnet Lake Ave Las Vegas NV 89113	Finance
Meghan Furtado		3195 Grand Ave #207 Pinellas Park FL 33782	Marketing
Spouse			
Spouse			
Spouse			

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School St Louis	Hawaii	89-92	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School Kaiser	Hawaii	92-96	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University University of Nevada Las Vegas		00-04	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Type of degree obtained, if any

College or university where obtained

Applicant's initial DT DT

5 MILITARY INFORMATION:A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch _____ Date of entry-active service _____

Date of separation _____ Type of discharge _____

Rating at separation _____ Serial number _____

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☐ No ☒

County _____ State _____ Date registered _____

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency
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B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes, furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒ If yes, when? _____ city, county and state _____

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒ If yes when? _____ city, county and state _____

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☒ If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
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Applicant's initial _____ DT DT
Page 4

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

- I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?

Yes ☐ No ☒ (Other than divorces)

If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
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- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?

Yes ☐ No ☒ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
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7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
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11/2014-16	3931 115 th Ave SE	Snohomish	WA 98290
2011-14	12808 Robinhood LN	Snohomish	WA 98290
2009-11	15740 1 st Ave NW	Shoreline	WA 98177
2008-09	17600 134 th Ave	Benton	WA
2006-08	12956 N. 154 th LN	Surprise	AZ
2004-06	Unknown	Phoenix	AZ
2000-04	Unknown	Las Vegas	NV
1996-00	Unknown	Hawaii Kai	Hi
1992-96	Unknown	Waimanalo	Hi

Applicant's initial DT DT

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

DA Medical Group

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/08	3900 S. Hualapai Way Ste 105	Still employed
Title	Description of Duties	Name of Supervisor
CEO PFIZER	Manager	Self

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2006-2008	235 E. 42nd St. NY, NY 10017	Restructuring
Title	Description of Duties	Name of Supervisor
Sales Rep Schering-Plough	Sales	Bob Cook

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2003-2006	2000 Galloping Hill Road Kenilworth NJ 07033	
Title	Description of Duties	Name of Supervisor
Intern/Sales Rep Albertsons	Sales	David Boyd / Tristah Schaub

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2000-2003	10250 W. Charleston Blvd	School / Internship w/ Schering
Title	Description of Duties	Name of Supervisor
Stocker	Stocker Night Crew	Chris Harms

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2000-2003	10250 W. Charleston Blvd	School / Internship w/ Schering
Title	Description of Duties	Name of Supervisor
Stocker	Stocker Night Crew	Chris Harms

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
96-98 (est)	1234 S. Beretania Honolulu HI 96822	College
Title	Description of Duties	Name of Supervisor
CSR	Stocker / Customer Service Rep	

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
95-96 (est)	2560 McCarthy Mall	Moved
Title	Description of Duties	Name of Supervisor
Dominos Pizza	Pizza Maker	

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial DT D9 Page 6

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name <u>Matt Peters</u>	Home	<u>33512</u>	<u>CONSIDES</u>	<u>DR</u>	<u>Dave</u>	<u>5</u>
Employer <u>SELF</u>	Business	<u>10000 SE Main St</u>	<u>Stell</u>	<u>118</u>	<u>Portland</u>	
Name <u>Jeff Brower</u>	Home	<u>3139</u>	<u>Anthem</u>	<u>CA</u>	<u>Anthem</u>	<u>16</u>
Employer <u>SELF / DA</u>	Business	<u>Same</u>				
Name <u>Pat Finley</u>	Home	<u>2211 N. 85th St</u>	<u>Seattle</u>	<u>WA</u>	<u>98103</u>	<u>5</u>
Employer <u>SELF / DA</u>	Business	<u>Same</u>				
Name <u>Jessica Daley</u>	Home	<u>24182</u>	<u>San Giovanni</u>	<u>DR</u>	<u>Land o Lakes</u>	<u>20+</u>
Employer <u>DA Medical</u>	Business	<u>Same</u>			<u>34639</u>	
Name <u>Paul Bitar</u>	Home					<u>12</u>
Employer <u>Nevada State</u>	Business					

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☒

If yes, state type, where and years held

12. Have you ever applied for a city, county or state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☒ No ☐
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

DA Medical - Medical Sales, Snohomish, WA
RAMP - Staffing Company - Dallas, TX

Applicant's initial DT DT

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

If yes to the above, state where, when and for what reason:

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☒

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer) Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒



Date of photograph 7/15/16

Applicant's initial DT D.T.

STATE OF Washington

SS.

COUNTY OF Snohomish

I, Devon Thornton

being duly sworn, depose and say I have read the

foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant ☒ Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent, ☐ and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying for a manufacturer license in the State of Nevada.



Original Signature of Applicant

Subscribed and Sworn to before me this 8th day of

July, 2016



Notary Public

Print: Janel M Lacy

Commission expiration date: 08-27-18

Notary Public
State of Washington
Janel M Lacy

Commission Expires 08-27-18
(seal)

Applicant's initial DT DT

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 7/17/16

GENERAL INSTRUCTIONS

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All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Medical Device Equipment and Gases

Nature of License
HDG Medical LLC, A Nevada limited Liability Company 3900 S Hualapai Way, Suite 105, Las Vegas, NV 89147
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name Brouwer First Name Jeff Middle Name SCOTT

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Present Residence Address-Street or RFD 3139 WEST HUALAPAI COURT City ANTHEM State/Zip AZ 85086
Dates 6/1/2011 - PRESENT

Present Business Address 3900 STE 105 City LAS VEGAS State/Zip NV 89147
Dates 6/15/2016

Occupation CEO/OWNER/SALIES Phone: Residence _____ Business _____

Date of Birth 1 Place of Birth (City, County, State) JOLIET, IL

Age 49 Social Security Number _____ Sex MALE

Color of Eyes HAZEL Color of Hair BLACK Complexion FAIR Weight 174 Build MEDIUM Height 5'9"

Scars, tattoos or distinguishing marks and/or characteristics NONE

Are you a citizen of the United States? Yes ☒ No ☐ If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial JB

A. Current Marriage PHOENIX, MARICOPA, ARIZONA
 Date _____ City, County and State _____
 Spouse's full name (Maiden) CHRISTINA MARIA GARCIA S.S. No. _____
 Date of Birth _____ Place of Birth SAN DIEGO, CALIFORNIA
 Resident address 3139 WEST HUNTER CRT ANTHEM, AZ 85086
 Street City State Zip
 Telephone: Residence _____ Business 603-386-5852
 Spouse's employer DA MEDICAL GROUP Occupation VP OF HUMAN RESOURCES
 Address of employer 8584 GARWETT LAKE AVE, LAS VEGAS, NV 89113
 Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address

B. Child Support Information:

Please mark the appropriate response:

- ☒ I am not subject to a court order for the support of child.
- ☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- ☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial JB

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name

Address

Contact person

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-

in-law or legal guardian. If retired or deceased, list last address and occupation.

Name (Maiden)	Birth Date	Address	Occupation
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Father

WARREN BROWER

CHICAGO, IL

INSURANCE

Mother

KAYE BROWER

6306 MICHELEND, PHOENIX, AZ

TEACHER

Father-in-Law

GREG GARCIA

5924 BEA RD, PHOENIX, AZ

FIREFIGHTER

Mother-in-Law

LINDA GARCIA

111 N T-ROAD, PHOENIX, AZ

SALES ASSISTANT

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
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RYAN BROWER

4439 W MICHIGAN RD, PHOENIX, AZ

TEACHER

Spouse

Spouse

Spouse

Spouse

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School	LIGHT + LIFE, PHOENIX, AZ	1/15/79 - 12/15/80	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School	PHOENIX CHRISTIAN HIGH, PHOENIX, AZ	1/15/81 - 12/15/84	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University	ARIZONA STATE UNIVERSITY, TEMPE, AZ	1/15/85 - 12/15/89	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other			Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any BS - MANAGEMENT, BA - MARKETING

College or university where obtained ARIZONA STATE UNIVERSITY

Applicant's initial

JB

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch _____ Date of entry-active service _____

Date of separation _____ Type of discharge _____

Rating at separation _____ Serial number _____

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☐ No ☒

County _____ State _____ Date registered _____

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes, furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒ If yes, when? _____ city, county and state _____

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒ If yes when? _____ city, county and state _____

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☒ If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial _____ JB

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

- I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?

Yes ☐ No ☒ (Other than divorces)

If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
---	------------	--------------------------	------------------------	------------------

- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?

Yes ☐ No ☒ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
----------------	----------------	--

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
-----------------------------	-------------------	------	-----------------

5/1/2001 - PRESENT, 3139 WEST HUNTER CREEK, ANTHEM, AZ


11/30/1998 - 5/1/2001 5890 GLASSMANWAY, OGDEN, UT

11/20/1995 - 11/30/1998 2401 SUNSET MEADOW, TUCSON, AZ

8/1/1993 - 11/2/1995 128 GREENBERRY, CRYSTAL LAKE, AZ

11/15/1991 - 8/1/1993 SAC, AZ, SACRAMENTO, AZ

12/15/1989 - 11/15/91 TEMPE, AZ, TEMPE, AZ

Applicant's initial JB 

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year DA MEDICAL 11/14 - PRESENT	Name/Mailing Address of Employer/Business 8884 CANNETT AVENUE, LAS VEGAS NV	Reason for Leaving PRESENT
Title CEO/OWNER	Description of Duties MANAGE COMPANY	Name of Supervisor NONE
Month and Year 11/17 - 11/14	Name/Mailing Address of Employer/Business MEDASUR 15115 PARK BLVD, AUSTON, TX	Reason for Leaving SOLD COMPANY
Title VP OF SALES	Description of Duties BUILT AND MANAGED SALES	Name of Supervisor PERRY FORRESTER
Month and Year 11/14 - 5/1/16	Name/Mailing Address of Employer/Business SAUTONS MEDICAL, 3139 WEST HUNTER CWT	Reason for Leaving DESIGNED COMPANY
Title OWNER	Description of Duties EVERYTHING TO RUN BUSINESS	Name of Supervisor NONE
Month and Year 5/1/05 - 9/15/13	Name/Mailing Address of Employer/Business DEB WENSE SALLY LLC, 3139 WEST HUNTER CWT	Reason for Leaving DESIGNED COMPANY
Title OWNER	Description of Duties EVERYTHING TO RUN BUSINESS	Name of Supervisor NONE
Month and Year 11/8 - 11/11	Name/Mailing Address of Employer/Business NEUDARTS PHARMA, NEW JERSEY	Reason for Leaving STARTED NEW BUSINESS
Title SPECIALTY REP	Description of Duties SALES TO ALL DOCTORS	Name of Supervisor RACHEL BRITTAEN
Month and Year 9/96 - 11/8	Name/Mailing Address of Employer/Business PFIZER INC, STAMFORD, NY, NY	Reason for Leaving TOOK NEW JOB
Title SPECIALTY REP	Description of Duties SALES TO ALL DOCS	Name of Supervisor MICHAEL RANSOME
Month and Year 11/91 - 9/96	Name/Mailing Address of Employer/Business LOREAL COSMETICS, STAMFORD, NY, NY	Reason for Leaving TOOK NEW JOB
Title REGIONAL SALES	Description of Duties SELL TO KEY ACCOUNTS	Name of Supervisor WALTER BENJAMIN
Month and Year 1/1/90 - 11/91	Name/Mailing Address of Employer/Business ALBERTO CULVER, CHICAGO, IL	Reason for Leaving NEW JOB
Title SALES REP	Description of Duties SOLD TO DRUG STORES	Name of Supervisor DEAN WINGS

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial

JB

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name <u>ARMANDO VASIS</u>	Home	<u>1402 MEMORIAL</u>	<u>ATLANTA, AZ</u>			<u>22 YEARS</u>
Employer <u>COOK MED</u>	Business	<u>NEW JERSEY</u>				
Name <u>JOHN HINSON</u>	Home	<u>3133 DEDICATION</u>	<u>ANTHEM, AZ</u>			<u>11 YEARS</u>
Employer <u>APP DYNAMICS</u>	Business	<u>SAN JOSE, CA</u>				
Name <u>LANE ARNOLD</u>	Home	<u>5118 NEEDER ROAD</u>	<u>MINNAPOLIS, MN</u>			<u>14 YEARS</u>
Employer <u>PURVIS PHARMACY</u>	Business	<u>STAMFORD PHARMACY</u>				
Name <u>SCOTT KERRI</u>	Home	<u>9109 WEST CHAMBERLAIN</u>	<u>CHANDLER, AZ</u>			<u>28 YEARS</u>
Employer <u>VIP MATURE</u>	Business	<u>PHX, AZ</u>				
Name <u>TOM YOUNG</u>	Home	<u>22001 LANE MARY</u>	<u>ROSELAND, AZ</u>			<u>14 YEARS</u>
Employer <u>NOT EMPLOYED</u>	Business	<u>N/A</u>				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☒

If yes, state type, where and years held

12. Have you ever applied for a city, county or state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☐ No ☒

If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

Applicant's initial

JB R

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

If yes to the above, state where, when and for what reason:

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☒

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer) Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒



Date of photograph

7/15/16

Applicant's initial

JB

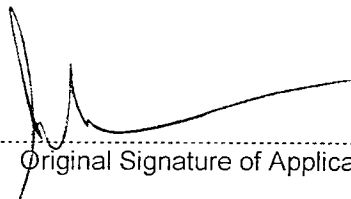
STATE OF California

SS.

COUNTY OF San Luis Obispo

I, Jeff Scott Brouwer, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

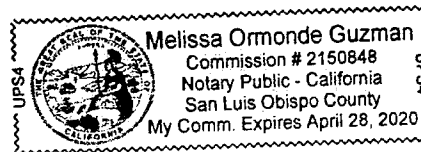
I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying for a manufacturer license in the State of Nevada.


Original Signature of Applicant


Subscribed and Sworn to before me this 7 day of

July, 2016

Melissa Ormonde Guzman
Notary Public



(seal)

Applicant's initial JB 
Page 9

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 7/15/10

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Medical Device Equipment and Gases

Nature of MDEG

HDG Medical LLC, A Nevada limited Liability Company 3900 S Hualapai Way, Suite 105, Las Vegas, NV 89147

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Thornton Christine Ninette
Last Name First Name Middle Name

Christine Wallace
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

8584 Garnet Lake Ave Las Vegas NV 89113
Present Residence Address-Street or RFD City State/Zip

3900 S Hualapai Way Ste 105 Dates Las Vegas NV 89147
Present Business Address City State/Zip

Administrator Dates
Present Position with the MDEG

Phone: 702-952-1705 Fax: 702-952-1706

Email address: CWT@DAMedicalGroup.com

Oklahoma City, Oklahoma
Date of Birth Place of Birth (City, County, State)

41 Female
Age Social Security Number Sex

Green Auburn 180 5'2"
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics Tattoo of a Bengal Tiger on lower left abdomen.

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

January 2015 - Present	DA Medical Group LLC, 3931 115th Ave SE, Snohomish, WA 98290	4,160
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
CFO/Controller	All Office Administration	Devin Thornton
Title	Description of Duties	Name of Supervisor
January 2009 to Present	Select Consulting Group, 3900 S Hualapai Way Ste 105, Las Vegas, NV 89147	16,640
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Owner/Operator	Business Support Services	Christine Thornton
Title	Description of Duties	Name of Supervisor
April 2003-January 2006	Millennium Properties & Development, 8665 W Flamingo Rd, Las Vegas, NV 89117	11,400
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Director of Operations	Day to Day Operations	Susan Licata
Title	Description of Duties	Name of Supervisor
Dec 2001- Apr 2003	Chavez & Koch, Sunet Road, Henderson NV 89052	3,120
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Director of Business Development	Business Development	David Chavez
Title	Description of Duties	Name of Supervisor
Apr 1999-Dec 2001	Prudential Financial, Howard Hughes Pkwy, Las Vegas NV	6,032
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Sales Assistant	General Office Duties to Brokers	Jerri Pratt
Title	Description of Duties	Name of Supervisor
June 1993-Apr 1999	Star Equipment, Hammond, LA 70403	12,480
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Office Manager	Manager Office and Employees	Trudy Ciolino
Title	Description of Duties	Name of Supervisor

I have ☐ I have not ☒ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☒ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☒ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☒ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information and provide a written explanation and/or documents.

- a) Board Administrative Action: State: _____
b) Date: _____
Case Number: _____
- c) Criminal Action: State: _____
Date: _____
Case Number: _____
County: _____
Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☒ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☒ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☒ No ☐

If you answer No to questions 4, 5 or 6 please provide a written letter of explanation.

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Date of photograph 7/15/16

I, Christine Wallace Thornton, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.


Original Signature of Applicant

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership – Pages 1,2,3,6
☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Helix Medical Equipment Inc.

Physical Address: 2780 S. Jones Blvd. Las Vegas, NV 89146
(This must be a business address, we can not issue a license to a home address)

Mailing Address: -

City: Las Vegas State: NV Zip Code: 89181

Telephone: _____ Fax: _____

E-mail: _____ Website: HELIXMEDICALEQUIPMENT.COM

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Presently we are not a store front business. See attached letter describing our current business model.

Mon: 9 to 1pm Tue: to Wed: to Thu: to

Fri: to Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Angelo Petrilli and or Deborah Petrilli

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

☐ Medical Gases** ☐ Assistive Equipment
☒ Respiratory Equipment** Small volume nebulizers and accessories ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☐ Orthotics and Prosthesis
☐ Diabetic Supplies Other: To be determined

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Angelo Michael Petrilli Telephone: 775 343-2540

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

N/A	in process			

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ☒
- 2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☒
- 3) Are any of the owners health professionals? If yes, please check the box and list name.
- | | | |
|---|-------|-----|
| <input type="checkbox"/> Practitioner | Name: | N/A |
| <input type="checkbox"/> Advanced Practitioner of Nursing | Name: | N/A |
| <input type="checkbox"/> Physician's Assistant | Name: | N/A |
| <input type="checkbox"/> Physical Therapist | Name: | N/A |
| <input type="checkbox"/> Occupational Therapist | Name: | N/A |
| <input type="checkbox"/> Registered Nurse | Name: | N/A |
| <input type="checkbox"/> Respiratory Therapist | Name: | N/A |

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

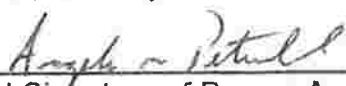
Within the last five (5) years:

- 1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

If the answer to questions 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG provider or wholesaler may be grounds for the revocation of this permit.


I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.



Original Signature of Person Authorized to Submit Application, no copies or stamps

ANGELO PETRILLI

Print Name of Authorized Person


Date

Board Use Only

Received: 6/28/16

Amount: \$500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICLY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: P/A

Corporation Name: Helix Medical Equipment Inc.

Mailing Address: _____

City: Las Vegas State: NV Zip: 89131

Telephone: _____ Fax: _____

Contact Person: Angelo Petrilli

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) Angelo Petrilli
Name Address

b) P/A
Name Address

c) _____
Name Address

d) _____
Name Address

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

2) Provide the number of shares issued by the corporation. 1000

3) What was the price paid per share? \$5

4) What date did the corporation actually receive the cash assets? June 9, 2016

5) Provide a copy of the corporation's stock register evidencing the above information

June 10, 2016

Nevada State Board of Pharmacy
431 Plumb Lane
Reno, NV 89509

Dear Board

Helix Medical Equipment ("Helix" or "we")) respectfully requests licensing as a DMEG supplier in Nevada. We would like to commence our retail sales activity in early August 2016.

We are a newly formed company incorporated in Nevada on June 9, 2016. Helix's initial focus as a retail supplier of medical equipment will be on enhancing the health care experience and outcomes of those precious children who, while economically disadvantaged, are being treated by pediatric physicians and other pediatric focused medical service providers who are enrolled with Nevada Medicaid as an Ordering, Prescribing or Referring provider ("OPR")¹ Accordingly, we are in the process of enrolling with Nevada Medicaid and Nevada Check Up (collectively (Medicaid), subject to Board licensing.

Given my extensive experience working as a professional and executive in a regulated industry for over 27 years, I value, welcome and appreciate the regulator's role and the importance of earning your trust and in building a strong working relationship. In this spirit, I thought it would be helpful to provide you with some additional background that I hope will help you better understand (i) our business model (ii) my qualifications to serve as the Administration and (iii) the purpose for our Nevada facility and our publicly posted hours of operation.

Business model

As stated above, our initial focus will be to improve the health care experience and outcomes of children and other consumers who have a medical need for the use of a nebulizer. We will do this by placing our nebulizer products (compressors and accessories) at physician offices for our retail sale to consumers. OPRs will have the option to refer our product to their patients.¹ OPRs have told us that the healthcare experience of the patient, caregivers and the OPR is greatly enhanced when our product can be provided to the patient (our consumer) before he/she leaves the OPR's facility. This occurs because (i) the patient (and his/her caregiver) can immediately interact and get acquainted with our product nearly at the same moment that the OPR determines a medical need for a nebulizer [a potentially disconcerting moment for the patient], (ii) immediate availability at the doctor's office is a great convenience to the caregiver who otherwise would have to find the product on her/his own [and given all the choices out there, may end up with a lower quality or inappropriate product], (iii) the child/patient can start treatment right away rather than waiting [perhaps even a few days] while the caregiver searches for the product elsewhere, (iv) the OPR will instruct the patient and caregiver on how to set up, use, and maintain the product in a way consistent with the product's design while the patient explores and interacts with the product, (v) by allowing the preceding to happen in the doctor's office, the OPR has a unique opportunity to further enhance his/her reputation and relationship with the patient and caregiver and, (vi) because our pediatric compressor/nebulizers are modeled in child

1. Title to the product will be retained by Helix until sold at retail to a consumer. No OPR or his/her employer has any direct or indirect financial interest in Helix, nor receives any remuneration for referring our product to their patients. (NAC 639.6941 1(i)).

And

friendly shapes such as trains, fire trucks, penguins, puppies other familiar "fun" shapes, the child will be much more eager to try and use it, thereby potentially enhancing the desired medical outcome.

We will initially carry a limited line of products, primarily comprised of compressors for use with a nebulizer and related accessories. As a retailer, we are selling only new products; and do not foresee renting any products to consumers. The retail box for our compressors for use with a nebulizer will include the manufacturer's written information to comply with NAC 639.6954 (2) and (5).

While we are a retailer of DME to consumers, we are not, nor shall we be in the foreseeable future, a store-front business.

None of our products require a prescription by law for it to be sold to consumers. Nonetheless, we will comply with NAC 639.6949 when we sell our products to consumers pursuant to a referral from a POR who has written a prescription or order, or where we have documented a verbal prescription or order.

We believe that our business model, as described above, serves the public interest and complies with the requirements of NAC 639.6946 (1) (a), (b), (c) and (d) and, along with the records that we will maintain, with the communication requirements set forth in NAC 639.6951 and NAC 639.6952.

We will not be providing repair services [NAC 639.6946 (1) (e) (2), (j) and (2)] at our facility, but rather will address such matters by replacing the product from our inventory or by returning the product to the manufacturers for replacement subject to their manufacturer's warranty.

We will not be providing any oxygen or medical gases. [NAC 639.6954 (1) (a), (b), (c), (d), (e), (f); (3), and (4)]. None of our products require calibration [NAC 639.6946 (3)].

We will not be designing, fabricating or manufacturing medical products.

We will not be providing medical or therapy services that require professional licensure or registration.

Facility Administrator Role

As stated earlier and as outlined in my Personal History, I have 27 years of extensive experience as an executive and client serving professional (CPA) in a regulated industry; and I have served clients in numerous industries, including medical equipment, where I advised on business processes and operations. I have spent considerable time understanding all applicable rules and regulations along with the quality standards of MDEG suppliers in Nevada; and we will operate accordingly. I am also Helix's sole shareholder and it's President; and therefore have a direct and substantial interest in ensuring that Helix operates in full compliance with all mandated federal, state and local laws, regulations, rules and standards of care. We will be using HIPPA compliant cloud based applications that will allow me to effectively manage the business on a daily basis irrespective of whether I am physically present at all times at the facility. Customers will be able to reach me directly. I will be on-site often. I believe I am well qualified to serve as the MDEG Administrator for Helix.

My co-Administrator, should the Board deem it necessary, will be Debbie Petrilli, who has 26 years of experience as a registered nurse in various settings (i.e. oncology, medical surgical floor and intensive care). Presently, Debbie provides me with insights related to public health care matters. Debbie is an employee and has no ownership interest in Helix.

Ar>

Furthermore, Helix's Manager of POR/Clinic Relationships will be on-site in Nevada. He has been trained by and has worked with another DMEG supplier outside of Nevada who has a similar business model; and within several more months he will have the hours of experience with Helix to also qualify as the Administrator in Nevada. He and I will be communicating daily.

Nevada Facility and Hours of Operation

We will maintain a small (330 sf) office in Las Vegas that will serve primarily as a base for receiving and distributing our products. We may also process customer intake forms and store the physical records of activity with consumers and communications therewith (including complaints) at our Nevada facility, though given our use of HIPPA compliant cloud based applications, we will be able to do the same with respect to these record keeping functions concerning Nevada customers from our facility in Massachusetts. Regardless of where stored, such records shall be readily accessible pursuant to NAC 639.695 through our cloud based HIPPA compliant applications or in physical form, as appropriate. Our Nevada facility will meet the requirements of NAC639.6946 (1) (e), (f), (g), (h) and (i).

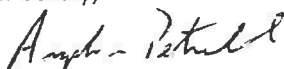
Given the primary purpose of our Nevada facility as described above as an inventory receiving and distribution center, and because we are not a store-front retailer, we would like to limit our posted hours of operations with respect to the public to a minimum (say 9am to 1pm on Mondays). This will allow our team to focus on executing on our business model, which requires them to be in the offices of PORs during most regular business hours. Paperwork processing would occur after normal business hours. We will be accessible full time to the public by phone, fax or email; and will respond promptly. Frankly, we anticipate few, if any, visitations to our facility by the public. We believe having the minimum hours posted for public access as previously stated meets the requirements of 639.6946 (4). As we grow, we can expand our public hours of operations as warranted.

I trust the Board will find the above helpful and will allow you to grant Helix Medical Equipment Inc. a DMEG license in time for us to commence sales in early August 2016.

Our desire is to sell to retail consumers through what we believe to be an effective business model that is in the public's interest and that is superior to on-line, mail-order and perhaps even many store-front and HME durable medical equipment retailers already selling similar products to Nevada consumers.

If you have any questions, please call. Your comments and suggestions are welcomed.

Sincerely,



Angelo Petrilli
President
Helix Medical Equipment Inc.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Confidential

Date May 2, 2016

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made herein is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for MDEG supplier
Nature of License
Helix Medical Equipment Inc. 2780 S. Jones Blvd, Las Vegas NV 89146
Name and Address of Establishment for Which License Is Requested
n/a
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Petrilli Angelo N
Last Name First Name Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Hanover MA
Present Residence Address-Street or RFD City State/Zip

Helix Medical Equipment Inc. 6/8/16 Las Vegas NV 89131
Present Business Address Dates City State/Zip

President 6/8/16
Occupation Dates

Pittsburgh, Allegheny, PA Residence Business
Phone: Residence Business

56 Male
Date of Birth Age

Brown Brown Caucasion 250 Broad 6'1"
Color of Eyes Color of Hair Complexion Weight Build Height

Scars, tattoos or distinguishing marks and/or characteristics n/a

Are you a citizen of the United States? Yes ☒ No ☐ If alien, registration No. _____

If naturalized, certificate No. _____ Date _____

Place _____ (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial AP

MARITAL INFORMATION-Continued

A. **Current Marriage** _____ Monroeville, Allegheny, PA
 Spouse's full name (Maiden) _____ Deborah Petrilli (Gorsalus) _____
 Date _____ City, County and State _____
 S.S. No. _____
 Date of Birth _____ Place of Birth Pittsburgh, PA
 Resident address _____ Hanover _____ MA _____
 Street _____ City _____ State _____ Zip _____
 Telephone: Residence _____ Business _____
 Spouse's employer _____ Occupation _____
 Address of employer _____
 Street _____ City _____ State _____ Zip _____

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
n/a				

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
n/a					

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address

B. Child Support Information:

Please mark the appropriate response:

- ☒ I am not subject to a court order for the support of child.
- ☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- ☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial Ar

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name n/a

Address _____

Contact person _____

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-

in-law or legal guardian. If retired or deceased, list last address and occupation.

Name (Maiden)	Birth Date	Address	Occupation
Father			
Antonio Petrilli	Deceased	Monroeville, PA	Broadcast Engineer
Mother			
Maria Petrilli	Deceased	Monroeville, PA	Teacher
Father-in-Law			
Lynn Harrison	Deceased	Scottsdale, AZ	Contractor
Mother-in-Law			
Darlene Harrison		Scottsdale, AZ	Real estate agent

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
Anthony Petrilli		Far Hills, NJ	CEO
Spouse			
Susan Petrilli (Sach)		Far Hills, NJ	Nurse
Robert Petrilli		Monroeville, PA	CFO
Spouse			
Mary Jane Petrilli (Barrone)		Monroeville, PA	Teacher
Marco Petrilli		Fort Worth, TX	Teacher
Spouse			
Laurie Petrilli		Fort Worth, TX	Flight Attendant
Spouse			

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University	Pennsylvania State University	1978-1982	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other			Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any B.S. Accounting, with distinctionCollege or university where obtained Pennsylvania State University

Applicant's initial

Am7

5 MILITARY INFORMATION:

- A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch _____ Date of entry-active service _____

Date of separation _____ Type of discharge _____

Rating at separation _____ Serial number _____

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

- B. Have you registered for the draft? Yes ☐ No ☒

County _____ State _____ Date registered _____

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

- A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency
n/a					

- B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes, furnish details on page 10.
- C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒
- D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒
- E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒
- F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒ If yes, when? _____ city, county and state _____
- G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒ If yes when? _____ city, county and state _____
- H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☒ If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial ARD

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

- I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?

Yes ☐ No ☒ (Other than divorces)

If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
--	------------	-----------------------	------------------------	------------------

N/A

- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?

Yes ☐ No ☒ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
----------------	----------------	---

N/A

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
--------------------------	-------------------	------	-----------------

Oct. 2001- present(Apr 2016)

Hanover

MA

May 1994 - Oct 2001

10267 N.136th Street

Scottsdale

AZ

Applicant's initial

Am

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Mar 1999 - Jan 2016	Ernst&Young LLP, Boston MA	Retired
Title	Description of Duties	Name of Supervisor
Executive	Partner / Certified Public Accountant	n/a
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Feb 1999	Great Western Publishing, Phoenix AZ	Sold company
Title	Description of Duties	Name of Supervisor
CFO	Finance	n/a
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jul 1996	Self Employed , Scottsdale AZ	Joined Great Western Publishing
Title	Description of Duties	Name of Supervisor
Consultant	Finanical consulting	n/a
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
May 1993	Bell Sports , Scottsdale AZ	Company restructuring
Title	Description of Duties	Name of Supervisor
VP Finance	Finance and accounting	n/a
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jun 1982	Price Waterhouse, Phoenix AZ	New job opportunity
Title	Description of Duties	Name of Supervisor
Sr.Manager	CPA/ Client service accounting professional	n/a
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial Ar

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Dayton Nordin	Home	Hingham, MA				12
Employer Ernst & Young LLP	Business	200 Clarendon St.	Boston, MA	02116		
Name Roslyn Guy	Home	Lowell, MA				15
Employer Ernst & Young LLP	Business	200 Clarendon St.	Boston, MA	02116		
Name Gary Silaci	Home	Lynn, MA				12
Employer Ernst & Young LLP	Business	200 Clarendon St.	Boston, MA	02116		
Name Debbie Tornabeni	Home	Las Vegas, NV				20
Employer n/a	Business	n/a				
Name David MacKinnon	Home	Newton, MA				15
Employer Ernst & Young LLP	Business	200 Clarendon St.	Boston, MA	02116		

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A			

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☒ No ☐

If yes, state type, where and years held

.....
Certified Public Accountant (CPA), MA 16 years

.....
Certified Public Accountant (CPA), AZ 12 years

12. Have you ever applied for a city, county or state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☒ No ☐
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

.....
Ernst & Young LLP US (as a partner from 1999 to Jan 2016 - retired). I was one of 2,800+ partners in this international, \$28 billion revenue firm.

.....
The firm's primary regulator in the United States is the Public Accounting Oversight Board (PBAOB); along with the Securities and Exchange Commission ("SEC")

.....
Also subject to numerous standards boards, including the Financial Accounting Standards Board (FASB); and membership in the AICPA and the MA State Board of Accountancy

Applicant's initial AND
Page 7

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

If yes to the above, state where, when and for what reason:

n/a

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☒

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer) Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒



Date of photograph 6/10/2014

Applicant's initial ARD

STATE OF Massachusetts

SS.

COUNTY OF Plymouth

I, Angelo Petrilli, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Angelo Petrilli

Original Signature of Applicant

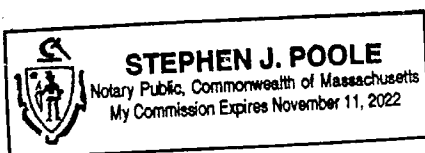
Personal information and personal history has been provided on a confidential basis and is only to be used by persons with a need to know for purposes of granting a NEVADA Pharm license / Ap?

Subscribed and Sworn to before me this 14 day of

June, 2016

[Signature]
Notary Public

(seal)



Applicant's initial AP

APPLICATION TO BE THE MDEG ADMINISTRATOR

157

Person who runs the facility on a daily basis

Date June 10, 2016

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Durable medical equipment administrator.

Nature of MDEG

Helix Medical Equipment Inc. 2780 S. Jone Blvd. Las Vegas NV 89146

Name and Address of Business for Which MDEG Administrator Is Requested

N/A - Newly formed company in NV

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Petrilli Angelo N.
Last Name First Name Middle Name

n/a
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

554 Hanover MA
Present Residence Address-Street or RFD City State/Zip

554 Las Vegas NV 89131
Present Business Address City State/Zip

President / sole shareholder Since formation on June 8, 2016
Present Position with the MDEG

Phone: Fax:

Email address:

 Pittsburgh, Allegheny, PA
Date of Birth Place of Birth (City, County, State)

56 M
Age Social Security Number Sex

Brown Brown 250 6'1"
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

see attached.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
-------	-----------------------	--------------------

1. I have ☐ I have not ☒ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☒ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☒ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

a) Board Administrative Action: State: NY

Date: _____

Case Number: _____

c) Criminal Action: State: MA

State: MA

Date: _____

Case Number: _____

County: _____

Court: _____

4. Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☒ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☒ No ☐

6. Will you be present at the site of the MDEG during its normal operating hours? Yes ☒ No ☐

If you answer No to questions 4, 5 or 6 please provide a written

see attached



Date of photograph 6/10/2016

I, Angelo Petrilli, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Angelo Petrilli

Original Signature of Applicant

Personal information of applicant has been provided on a confidential basis and is not to be shared with persons who have a need to know for purposes of granting a Nevada MDEG license/A.

APPLICATION TO BE THE MDEG ADMINISTRATOR

254

Person who runs the facility on a daily basis

Date June 10, 2016

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Durable medical equipment administrator.

Nature of MDEG

Helix Medical Equipment Inc. 2780 S. Jone Blvd. Las Vegas NV 89146

Name and Address of Business for Which MDEG Administrator Is Requested

N/A - Newly formed company in NV

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Petrilli Deborah Lynn
Last Name First Name Middle Name

n/a

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Present Residence Address-Street or RFD City State/Zip

5913 Lone Ranch Ave Dates Las Vegas NV 89131

Present Business Address City State/Zip

Public Health Advisor Dates Since formation on June 8, 2016

Present Position with the MDEG

Phone: Fax:

Email address:

Date of Birth Pittsburgh, Allegheny, PA
Place of Birth (City, County, State)

54 Age Social Security Number F Sex

Brown Brown 145 5'5"
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No. 1/1

If naturalized, certificate No. 8 Date

Place (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

2004 to 2016	Partners Health Care / Massachusetts General Hospital Fruit Street, Boston MA	1500+
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Registered Nurse	Intensive care unit - patient care	n/a
Title	Description of Duties	Name of Supervisor
1990 to 2001	Scottsdale Memorial Hospital Shea Blvd, Scottsdale AZ	1500+
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Registered Nurse	Oncology unit, Surgical unit, then Intensive care unit - patient care	n/a
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

I have ☐ I have not ☒ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☒ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☒ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☒ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information and provide a written explanation and/or documents.

- a) Board Administrative Action: State: MI
b) Date: J
Case Number: J
c) Criminal Action: State: MI
Date: J
Case Number: J
County: J
Court: J

4. Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☒ No ☐

5. Will you be employed fulltime with the MDEG? Yes ☒ No ☐

6. Will you be present at the site of the MDEG during its normal operating hours? Yes ☒ No ☒

If you answer No to questions 4, 5 or 6 please provide a written letter c

see attached

ATTACH

TAKE

30



Date of photograph 6/10/2016

I, Deborah Petrilli, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Deborah A. Petrilli

Original Signature of Applicant

Personal information of applicant has been provided on a confidential basis and only to be shared with or used by persons who have a need to know for purposes of granting a Nevada MDEG license. / DP